HICS 260 – PATIENT EVACUATION TRACKING FORM

1. DATE	2. UNIT	
3. PATIENT NAME	4. AGE	5. MR #
6. DIAGNOSIS (-ES)	7. ADMITTING PHYSICIAN	

8. FAMILY NOTIFIED

☐ YES ☐ NO CONTACT INFORMATION:

9. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY

☐ Hospital Bed	☐ IV Pumps	☐ Isolette/Warmer	☐ Foley Catheter
☐ Gurney	☐ Oxygen	☐ Traction	☐ Halo-Device
☐ Wheel Chair	☐ Ventilator	☐ Monitor	☐ Cranial Bolt/Screw
☐ Ambulatory	☐ Chest Tube(s)	☐ A-Line/Swan	☐ IO Device
☐ Other	☐ Other	☐ Other	☐ Other

ISOLATION ☐ YES ☐ NO TYPE

REASON

10. DEPARTING LOCATION		11. ARRIVING LOCATION	
ROOM#	TIME	ROOM #	TIME
ID Band Confirmed ☐ YES ☐ NO	By:	ID Band Confirmed ☐ YES ☐ NO	By:
Medical Record Sent ☐ YES ☐ NO		Medical Record Sent ☐ YES ☐ NO	
Addressograph Sent ☐ YES ☐ NO		Addressograph ☐ YES ☐ NO	
Belongings ☐ with Patient ☐ Left in Room ☐ None		Belongings Received ☐ YES ☐ NO	
Valuables ☐ with Patient ☐ Left in Safe ☐ None		Valuables ☐ YES ☐ NO	
Medications ☐ with Patient ☐ Left on Unit ☐ to Pharmacy		Medications Received ☐ YES ☐ NO	
PEDS/INFANTS			
Bag/Mask with Tubing Sent ☐ YES ☐ NO		Bag/Mask with Tubing Received ☐ YES ☐ NO	
Bulb Syringe Sent ☐ YES ☐ NO		Bulb Syringe Received ☐ YES ☐ NO	

12. TRANSFERRING TO ANOTHER FACILITY

TIME TO STAGING AREA	TIME DEPARTING TO RECEIVING FACILITY
DESTINATION	
TRANSPORTATION ☐ Ambulance Unit ☐Helicopter ☐ Other:	
ID BAND CONFIRMED ☐ YES ☐ NO BY: (please print)	
DEPARTURE TIME	
13. FACILITY NAME	

PURPOSE: Document details and account for patients transferred to another facility. **ORIGINATION:** Medical Care Branch Director
ORIGINAL TO: Patient **COPIES TO:** Patient Tracking Manager and Departing Location